Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Antiseizure Agents: fenfluramine (FINTEPLA)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Does the member have paid claims for greater than or equal to (≥) 60 days fenfluramine (FINTEPLA) in the last 90 days?

- ◯ Yes (Approve - 365 days)
  (Go to #13)
- ◯ No
  (Go to #7)

7. Is the member greater than or equal to (≥) two (2) years of age?

- ◯ Yes
  (Go to #8)
- ◯ No (Deny)
  (Go to #8)

8. Does the member have a diagnosis of Lennox-Gastaut syndrome or Dravet syndrome in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Is the member taking clobazam (ONFI, SYMPAZAN) and stiripentol (DIACOMIT) concurrently with fenfluramine (FINTEPLA)?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #11)

10. Is the requested dose less than or equal to (≤) 17 mg/day?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

11. Is the requested dose less than or equal to (≤) 26 mg/day?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Has the member had therapy with an monoamine oxidase (MAO) inhibitor in the last 14 days?

Examples of MAO inhibitors include: linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), rasagiline mesylate (AZILECT), selegiline (EMSAM, ZELAPAR), tranylcypromine (PARNATE), and XADAGO

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No (Approve - 365 Days)
  (Go to #13)

Additional Information

13. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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